FOR Families Program Evaluation Project

Final Results

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1. SUMMARY

This report presents the final findings of the formative and process evaluation of the FOR Families Program. Data presented herein were gathered between May and August 2010 from four main data sources: face-to-face interviews with clients in motels, telephone interviews with home visitors, the FOR Families database for the period of October 2008 to March 2010, and the pilot review of client assessment forms. Five key questions were employed to guide this evaluation: (1) What patterns of follow-up, outreach, and referral emerged from the data documenting these activities vis-à-vis patterns of need? (2) What challenges did the program encounter during the last 12 months? (3) What factors facilitated the transition of families out of motels? (4) What are the biggest barriers that families face? (5) From the families' perspective, what are the most important factors for making progress out of homelessness?

1.1. Summary of Key Findings

Key Questions

1. What patterns of follow-up, outreach, and referral emerge from the data documenting these activities vis-à-vis patterns of need?
    - Analysis of data obtained from the FOR Families database reveals a higher number of referrals among families with 2, 3, and 4 members than families with 1 or 5 or more members.
    - All families – regardless of family size, number of children, or region – appear to be receiving (on the average) an equal number of follow-up contacts from home visitors.
2. What challenges did the program encounter during the last 12 months?
    - Analysis of qualitative data obtained from interviews with families and home visitors indicates that among the challenges encountered were lack of affordable housing, large caseloads, limited funding resources, and limited time with the families to address a complex array of needs. The program also went from serving a small sub-group of families in family shelters, and/or providing stabilization services for families newly housed, to working exclusively with all families placed in motels. The program's funding agency changed from the Department of Transitional Assistance to the Department of Housing and Community Development.
3. What factors facilitated the transition of families out of motels?
    - Although the data collected do not answer this question directly, when length of stay is examined, the factors that appear to facilitate a home visitor's ability to make referrals for services that facilitate the transition of families out of motels into a more stable housing, include (a) small or large family size and (b) ability to secure subsidized housing. The majority exit the hotel when a unit opens in a family shelter that is appropriate for the family's size and location.
4. What are the biggest barriers that families face in their transition to more stable housing?
    - Lack of employment, finances, low educational levels, availability of public funds to support subsidized housing, lack of transportation, affordable housing, and lack of access to childcare (particularly for single mothers) are the dominant themes that emerged from interviews with families as the biggest barriers that families face to transition out of the motels into a more stable housing situation . The majority go to a family shelter.

5. From the families' perspective, what factors are most important for making progress out of homelessness?
    - Families identified access to affordable housing, transportation, and jobs as the main factors that would facilitate a faster transition out of homelessness.

Interviews with heads of family units: Key findings

1. Face-to-face interviews with 43 clients (also referred to in this report as "heads of family units" or "heads of household") were conducted.
2. The most common demographic profile of a homeless family drawn from the data is a family composed of a single woman with two young children who are typically under 5 years of age. She is in her late twenties and has a high school education.
3. Over 50% of all family members in the sample population were children under the age of 17, and the largest segment consisted of children under the age of 5.
4. Reasons for becoming homeless, as reported by the families interviewed, include losing jobs, inability to afford rent, inability to continue living with relatives or friends, natural events (e.g. earthquake in Haiti, floods) and accidents (e.g. car accidents, work-related accidents). Inability to continue living with relatives because of conflicts, housing restrictions, and other family situations were the most commonly reported reasons for becoming homeless.
5. Nearly all clients interviewed reported some type of health problem among family members in their family units. Mental health, primarily depression, was among the most common health problems reported. Skin rashes and upper respiratory problems were the second most commonly reported health problems.
6. Homeless families, particularly single mothers, had limited job skills and training. This factor, coupled with the presence of small children and the lack of consistent childcare, makes it difficult for single mothers to secure jobs and/or training opportunities.
7. Transportation emerged as a common barrier for families residing in motels. A lack of transportation limited their ability to seek a job consistently or to reach social service agencies to which home visitors had made referrals.
8. Lack of cooking facilities, limited ability to prepare nutritious meals, and lack of play areas for children were common themes identified by clients as difficulties of residing in motels.

Interviews with home visitors (HV): Key findings

1. Telephone interviews were conducted with 14 FOR Families home visitors.
2. Home visitors reported an average caseload of 56 families.
3. The main challenges reported by home visitors were high caseloads, time constraints to assess families' needs and implement a more comprehensive case management plan, distance, travel time, and program rigidity.
4. Program strategies continue to be similar to the strategies implemented in the past: letters, information packages, direct advocacy, direct assistance with telephone calls and meetings with agencies, one-on-one teaching/coaching, and an establishment of direct links with programs and agencies. Strategies for follow-up, outreach, and referral are tailored to the specific needs of each family, which requires additional time and effort from the home

visitor. Tailoring appears to be compromised because of the limited time that home visitors have with the families living in motels.

5. Lack of a formal system of service coordination for homeless families was reported by most home visitors. Home visitors indicated that they collaborate with a wide range of agencies. They also pointed out that the coordination of services for homeless families in the context of these collaborations is initiated and carried out by FOR Families home visitors.
6. Home visitors reported that care coordination with housing agencies and the school system works well.
7. Program components that home visitors identified as working well include commitment to helping families, response/assistance from the health care community, diverse and committed staff, program mission, and housing pilot programs to help families move out of the motels.
8. Accomplishments that home visitors identified include prevention of more severe crises; ability to empower families; ability to provide referrals and through this strategy successfully link families with employment opportunities and housing; being able to see families at least once despite a large caseload; and providing appropriate referrals for schools, education, food, and job training given the unique needs of each family.

FOR Families database: Key findings

1. A total of 4,383 unique client records were obtained from the FOR Families database for the 18-month period starting October 2008 and ending March 2010. These records represent families enrolled in the FOR Families Program and temporarily sheltered in motels.
2. The mean length of stay (measured in months) in the program was lower when families were composed of one family member (pregnant woman) (1.8 months) or when families had 5 to 6 members (1.6, 1.3 months), and higher when family size was 2, 3, 4 or 7+ members (3.1, 3, 2.2, 2.2 months respectively).
3. The mean number of contacts per client was higher (>10) among families with 1, 2, 3, 4 and 7+ members and lower among families with 5 and 6 members (<10).
4. The mean number of referrals per client to various services appeared to be the same regardless of family size or number of children in the family.

Initial record review: Key findings

1. Seventy-eight randomly selected family assessment forms were reviewed.
2. The mean age of heads of household in this sample was 28.5 (range 16 to 55 years old).
3. Reasons for homelessness in this subsample mirror the two other data sources: family reasons (e.g., doubling up, inability to continue living with relatives, conflict with family members), domestic violence, and lack of affordable housing/rent.

In general, demographic characteristics of families enrolled in the FOR Families Program, their reasons for becoming homeless, and their overall self-reported morbidity profiles were consistent across the three data sources.

2. INTRODUCTION

This report presents the final results of the 2010 FOR (Follow up, Outreach, and Referrals) Families Program Evaluation Project. This evaluation sought to answer questions about program implementation and to provide insights for program improvements. Data for this project were collected between the months of May and August 2010. The results are presented in four main sections:

- Results of interviews with heads of family units
- Results of interviews with home visitors
- Results of database analysis
- Results of record review

2.1. Program Background

The FOR Families Program was originally conceived in the context of welfare reform. FOR Families was implemented to provide follow-up, outreach, and referral services to families in the Transitional Aid to Families with Dependent Children program who were no longer eligible for cash benefits, or who were in the process of transitioning off the welfare program. The broad range of services and programs and the flexibility of Department of Public Health (DPH) made this program the ideal place to house the FOR Families program. Given the ramifications of policy changes on the health and well-being of mothers, children, and entire households, DPH emerged as the government agency with the best access to the appropriate programs and services to assist affected families.

However, over the past two years, the program has assisted homeless families in the Commonwealth of Massachusetts during several pilot and experimental projects. The program provides a critical service to homeless families by identifying and addressing barriers that prevent families from attaining and maintaining self-sufficiency and/or stable housing and by connecting the families to social and health services and resources. During the last two years, the program has focused on assisting families placed in temporary shelter in motels across the Commonwealth. FOR Families home visitors provide direct follow-up, outreach, and referral services to the families, who enter the program after being placed in motels by homeless coordinators from the Department of Housing and Community Development (DHCD).

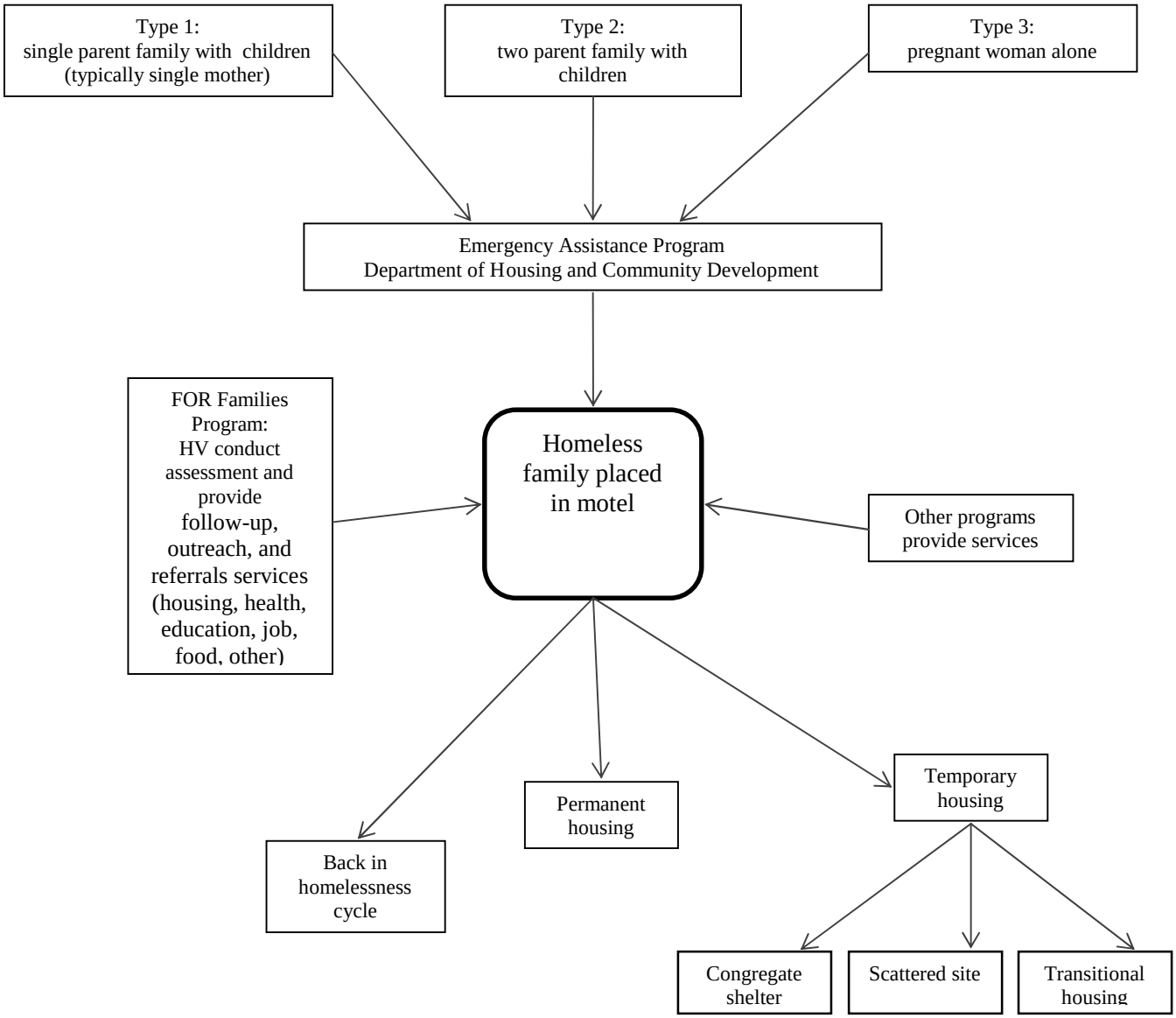
During this period, FOR Families home visitors have worked directly with staff from the DHCD. The DHCD is the first point of entry for the families into the system once they seek assistance (Figure 1). DHCD homeless coordinators conduct an initial eligibility assessment and then place the families in emergency shelter. If the shelters are full, motels are used. At this point, DHCD contacts FOR Families program staff, who follow up with the families and initiate the coordination of outreach and referral services while the families are in the motels. Presently, FOR Families services end once the family is moved into a new housing arrangement outside the motel/hotel.

Program activities and objectives

Activities: The main activities of the FOR Families Program are follow-up, outreach, and referrals.

Objective: The objective of the program is to assist homeless families in their transition out of motels to temporary or permanent housing.

Figure 1. Typology of families entering FOR Families and current route of entry and exit



2.2. Formative and Process Evaluation of the FOR Families Program

A formative and process evaluation design was implemented to assess the current state of the program. This study follows the 2006 qualitative program evaluation of FOR Families, which was conducted to identify the program's strengths and promising practices for working with homeless families; to assess the role of the FOR Families Program in facilitating the transition of

clients from homelessness into a more stable situation (which may be a shelter rather than a home); to inform the development of a homeless screening tool, a FOR Families home visitors protocol, and a program logic model; and to make recommendations for program improvements.

Drawing from the results of the 2006 evaluation, the present evaluation sought to re-assess the role of the FOR Families Program in facilitating the transition of clients out of the motels into a more stable housing situation, to examine the program's strengths and weaknesses in light of the new program conditions, to provide recommendations for outcome measures, and to provide a rationale for the continued support and funding of the program.

3. METHODS

3.1. Data Collection Methods and Evaluation Questions

Interviews with clients/heads of family units were conducted to gather families' perspectives regarding their experiences living in a motel/hotel and receiving services from the FOR Families Program while temporarily sheltered at the motel/hotel. Families were visited in four regions: Metro/Boston, Southeast, Northeast, and West. Interviews were conducted with the heads of family units. Flyers were distributed at the motels, and families were informed that two researchers from Indiana University would be visiting the motel/hotel to talk with them. At the time of the interviews, home visitors facilitated the identification of potential volunteers for the interviews. A convenience sample of 43 families residing in four motels was collected. The families were visited and interviewed in their motel rooms between May 10 and May 13, 2010.

Telephone interviews with home visitors were conducted between May 24 and June 1, 2010 by three researchers from Indiana University. Home visitors were contacted by email to arrange a time that was convenient to them to conduct the interview. These interviews included questions that explored programmatic challenges, service coordination, program strategies, and home visitors' accomplishments in their work with clients. Fourteen home visitors were interviewed during this period.

FOR Families database. Data from the FOR Families database were obtained from program staff and examined in July and October 2010. Demographic and program variables for 4,383 unique clients entered in the database between October 2008 and March 2010 were analyzed. Demographic characteristics and descriptive data for program activities were examined.

Initial record review. An initial record review was initiated to aid with the creation of client profiles. Seventy-eight active or recently active client records representing all regions were randomly selected. Clients' assessments at the time of entry into the program were copied and sent to the evaluation team at Indiana University. Seventy-eight records were received by August 2010. Demographic characteristics, self-reported health status, and housing history were the primary variables examined.

Table 1 presents the main guiding questions considered in this evaluation and the methods employed to collect the data.

Table 1. Guiding evaluation questions considered in this evaluation

Evaluation questions	Data collection method
How many families moved out of the motels in the last 18 months? Where did they go after exiting the motels? Into stable housing? Into shelters? With relatives?	FOR Families database*
What patterns of follow-up, outreach, and referral emerge from the data documenting these activities vis-à-vis patterns of need?	FOR Families database
What challenges did the program encounter during the last 12 months?	Interviews with families Interviews with home visitors
What factors facilitated the transition of families out of motels?	Interviews with families
What are the biggest barriers that families face as they move out of homelessness?	Interviews with families Interviews with home visitors
From the families' perspectives, what are the most important factors for making progress out of homelessness?	Interviews with families

*Notes: *This question could not be completely answered with the data collected.*

3.2. Data Analysis

Qualitative data from interviews with heads of family units and with home visitors were typed and entered into tables created in Microsoft Word ® and identified by question number and a unique ID number for each family and each home visitor interviewed. A general list of codes was developed a priori, directly derived from the questions in the interview schedules (see Appendices A & B). Three coders examined the data and coded the narrative obtained from the interviews with the families. Two coders examined the data and coded the narrative obtained from the interviews with home visitors. These codes examined the program's main activities (follow-up, outreach, and referral), programmatic challenges, areas for improvement, strategies that are working, reasons for homelessness, and what families need to transition out of homelessness. Frequencies in the response to the main questions were calculated for descriptive purposes and to summarize the responses of the clients and the home visitors interviewed.

Quantitative data obtained from the interviews with families were entered into Microsoft Excel® sheets for data management and then transferred to SPSS for analysis. Data from the FOR Families general database were securely retrieved via program server and entered into SPSS for analysis. Descriptive statistics were calculated for all demographic characteristics and for the programmatic variables of interest.

4. RESULTS

4.1. Interviews with Heads of Family Units

Family composition. Forty-three clients (heads of families/households) were interviewed between May 10 and May 13 throughout four regions served by the FOR Families Program, as follows: 15 from the Western region, 7 from Metro/Boston region, 13 from the North East region, and 8 from the South East region. The final convenient sample consisted of 119 family members residing in motels during the interview period. As shown in Table 2, most families (88%) were headed by a female, and over half of all sample members were female. Fifty-five percent of all members were children 17 years old and younger, and over half of this subtotal were children under 5 years old (Table 3). Forty of the 65 children (61.5%) were under the age of 5. Fifteen children out of the 65 (23.4%) were 12 months and younger.

Of the families interviewed, 23 had children in grades K to 12, 9 families had children in daycare, and 31 had infants or toddlers. Twenty-seven percent of the heads of family units were Black, 23.2% White, 41.8% Hispanic, and 6.9% of mixed ethnic backgrounds. Twenty-three percent of heads of household were foreign-born. Tables 2 to 6 show the family composition characteristics of the 43 clients interviewed and their domestic units.

Table 2. Clients interviewed: Family composition

Region	Male *f* (%)	Female *f* (%)	Total *f* (%)
Head of family/household	5 (12)	38 (88)	43 (36.1)
Partner of head of family/household	4	6	10 (8.4)
Children (<18)	38	28	65 (55.5)
Total	47 (39)	72 (61)	119 (100)

Table 3. Distribution of sample clients interviewed by age and region

Age group	NE *f* (%)	West/Central *f* (%)	Southeast *f* (%)	Metro/Boston *f* (%)	Total
≤5	12	15	7	6	40
6–10	3	5	2	3	13
11–13	1	0	1	1	3
14–17	0	3	3	3	9
18–19	0	1	1	2	4
20–24	7	15	2	1	25
25–35	8	2	3	4	17
35+	3	0	2	3	8
Total	34 (29)	41 (34)	21(18)	23 (19)	119 (100)

Table 4. Distribution of sample population by race/ethnicity and region

Race/ethnicity	NE *f* (%)	West *f* (%)	SE *f* (%)	Metro/Boston *f* (%)	Total *f* (%)
Black	10	5	9	5	29 (24)
Hispanic	8	32	2	13	55 (46)
White	16	3	2	3	24 (20)
Mixed/Biracial	0	1	8	2	11 (9)
Total	34 (29)	41(34)	21 (18)	23 (19)	119 (100)

Table 5. Number of non-U.S.-born heads of family unit

Country of origin	No. of families
Algeria	1
Cape Verde	2
Colombia	1
Dominican Republic	3
Haiti	3
Total	10

Educational levels of clients interviewed. More than half of the clients interviewed reported that they had completed a high school degree or less at the time of the interview, thirteen reported some college education, and four indicated having a college degree. Only 1 head of family unit had a graduate degree. Hispanic heads of household reported the lowest educational levels: 12 out of 18 had a high school diploma or less. White heads of family unit reported the highest educational levels: 6 out of 10 had some college or h eld a graduate degree. Tables 7 and 8 summarize educational levels of heads of family unit by age and ethnicity.

Table 6: Education of heads of family units by age group

Age group	Less than HS *f(%)*	HS *f(%)*	Some college *f(%)*	College *f(%)*	Graduate *f(%)*
18–19	2	0	0	0	0
20–24	8	5	7	0	0
25–35	5	1	5	3	0
35+	2	2	1	1	1
Total *f* (%)	17 (39.5)	8 (18.6)	13 (30.2)	4 (9.3)	1 (2.3)

Table 7. Educational levels of heads of family unit by self -identified race/ethnicity

Race/ethnicity	Less than HS *f*	HS/GED *f*	Some college *f*	College *f*	Graduate *f*	Total *f* (%)
Black	4	3	2	3	0	12 (28)
Hispanic	10	2	5	1	0	18 (42)
White	1	3	5	0	1	10 (23)
Mixed/biracial	2	0	1	0	0	3 (7)
Total *f* (%)	17 (39.5)	8 (18.6)	13 (30.2)	4 (9.3)	1 (2.3)	43 (100)

Self-reported morbidity. Clients interviewed were asked if they or any of their family members had experienced any health problems (i.e., ongoing or new, chronic or non -chronic, acute health problems) during the 30 days prior to the interview. Specific probes included health problems related to mental health, substance abuse, domestic violence, and disabilities. Thirty - nine clients (90.7%) reported at least one health problem in their families (Figure 2). Table 9 provides an inventory of all health needs and problems reported by clients. Depressi on was the most frequently mentioned health issue, followed by skin problems and upper respiratory/ asthma complaints. Other mental health problems reported include PTSD, bipolar disorders, panic attacks, and stress. These combined make mental health the h ighest contributor to the household burden of disease among the homeless families visited.

Figure 2. Number of family units experiencing health problems 30 days prior to interview

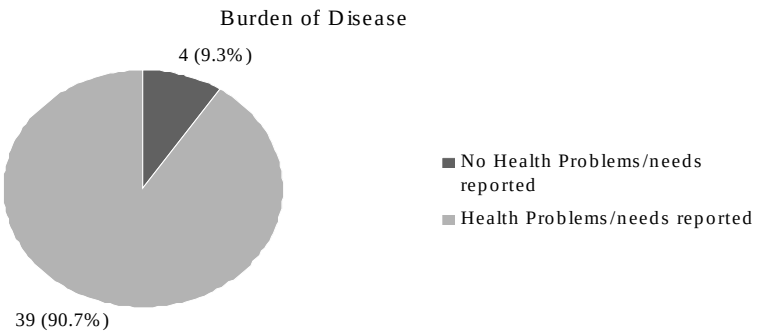


Table 8. Types of health problems reported by heads of family units affecting their households

Reported Health Issues	Number of times reported
None reported	4
Respiratory/ Asthma	19
Depression	17
Mental Health	14
Infections	13
Dermatology	12
Other	10
Lice, mice, bed bugs, roaches and spiders in r ooms	5
Behavior Problems	4
Neurologic/Seizures	4
Weight/Obesity/Wt loss	3
Pregnancy	3
Diabetes	1
Cardiac	1
Renal	1
Total	**111**

Length of stay in program and motels. At the time of data collection, families had spent, on the average, 86 days in the motels (Table 10). The length of stay ranged from 12 to 300 days. Over 50% of the sample had spent under 2 months in the motels, and 35% of the total had spent less than 30 days in the motels and in the program (Tables 10 & 11).

Table 9. Average length of stay of families in FOR Families Program and in motels

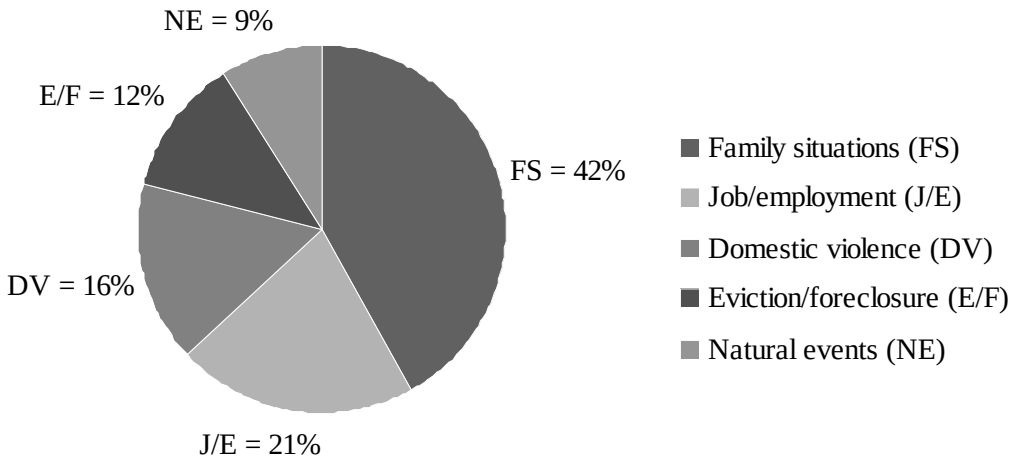
	Mean	Std Dev	Min	Max
Length of stay in days	86	77	12	300

Table 10. Distribution of length of stay of families in FOR Families Program in motels

Length of Stay (days)	*f*	*%*
≤30	15	35
31 – 60	9	21
61 – 90	4	9
91 – 180	9	21
180 – 270	5	12
≥271	1	2
Total	43	100

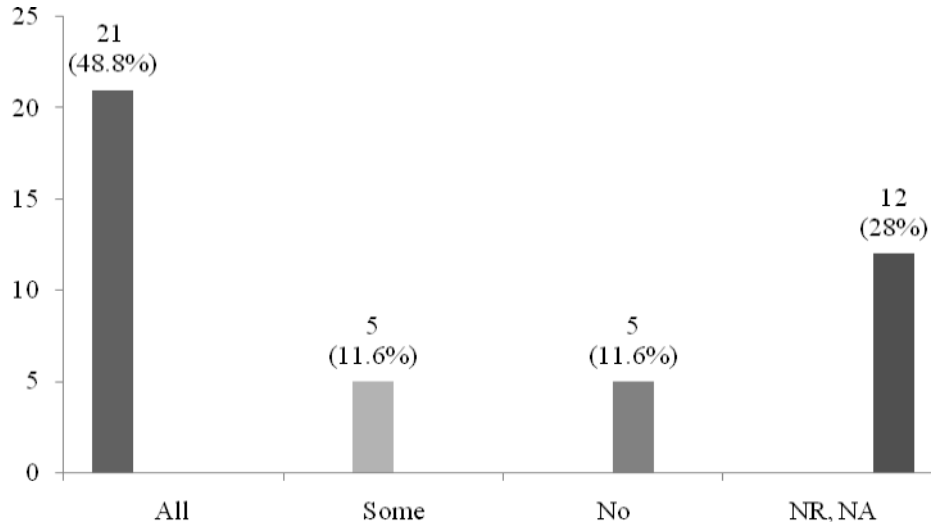
Becoming homeless. Families were asked why they became homeless. For most families becoming homeless was an experience that was shaped by multiple factors occurring simultaneously or as a chain of events, from domestic violence, losing jobs and housing, to conflicts with relatives and lack of employment opportunities (Figure 3). The inability to continue living with relatives due to family conflicts, doubling up, housing policies, and overcrowding conditions were the most common (42%) reasons provided by the clients interviewed as to why they became homeless. This was followed by financial difficulties and job loss (21%). Domestic violence was the main reason for becoming homeless for 16 % of the sample. Twelve percent of the families became homeless due to eviction or foreclosure, and 9% due to natural events (e.g., the earthquake in Haiti, fire, and flooding).

Figure 3. Reasons for becoming homeless



Services received since placement in motels. The majority of the clients interviewed reported that they are following the home visitors' recommendations (Figure 4). Most families (86%) indicated that they have received some type of service from the FOR Families Progr am. Families reported receiving referral and follow-up services in all categories, with referrals for housing, food security, and family economics as the most frequently reported type of referral . Sixty percent of the clients followed up on the recommenda tions provided by the home visitor, such as making a phone call to or visiting the social services or housing agency that was recommended. Nearly 12% of all families indicated that they followed up with some services, such as housing and food pantries, but did not follow up with other recommendations, such as referrals to social or community support. 11.6 % of families indicated that they did not follow up at all.

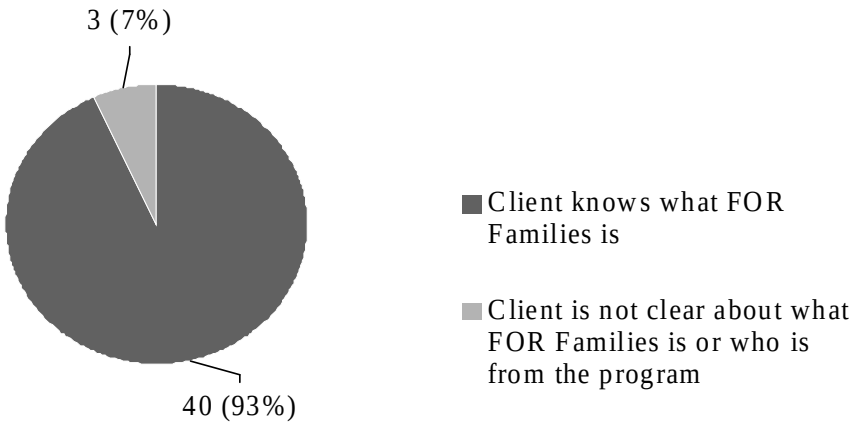
Figure 4. Number of families that followed up with Home Visitor recommendations to obtain services



Notes: NR= no response; DK = don't know; NA = not applicable (client had not been referred to services at time of interview; interviewee unable to determine if based on response if client had services such as WIC prior to entering program or received referrals while in program, clients did not differentiate referrals from FF staff vs. other agency staff)

FOR Families Program. Clients were asked to share their experiences with the FOR Families Program and how the program had been helpful to them and their families. Most clients interviewed indicated that the program has been helpful by providing either information packages and/or referrals to concrete services, such as daycare, food pantries, and health insurance. Forty clients (93%) indicated that they understand that the program provides information, referrals, and follow-up services (Figure 5). Nine of these clients indicated that while they know what the program does, they have not spoken with a FOR Families home visitor and have not found the program useful. One client who had been in the motel for 90 days at the time of the interview said, "*[I] haven't spoken with anyone, just met with [name of FF HV] last week*." Another client who had spent 120 days in the motel said, "*It feels like they have not done enough.*" Three clients indicated that they do not know what the FOR Families program is, what the program does, or who, among the various providers who visit them, comes from FOR Families. However, they gave the names of FOR Families home visitors when they mentioned individuals or providers who had been helpful. One client responded, "*What is FOR Families? I was placed here and given a guide, but nothing since then* ." Another client indicated, "*Who is from the FOR Families program? So many people come here that I don't know who is who. [Name of FF HV] is helpful*." These families had been in the motels for 30 days or less.

Figure 5. Clients' understanding of FOR Families program



Eleven clients indicated that they have received primarily information packages and a resource guide. These clients also reported that they received advice, counseling, and support. Twenty clients reported that they have found the program useful and could provide concrete examples of the type of referrals that they received from home visitors, which resul ted in tangible items or services, such as financial assistance, a housing voucher, or a letter for food pantries or clothing. Nine families (20.9%) felt that the program has not been helpful, has done nothing for them, or that they have not spoken with an yone from FOR Families. In general, the clients interviewed appeared to have similar experiences with the program regardless of their length of stay in the program, which ranged from 13 to 300 days. Table 12 summarizes the main themes that emerged from the qualitative data on clients' experiences with the FOR Families Program.

Table 11. Clients' experiences with the FOR Families Program by number of days in program

Main themes	No. of clients who shared similar experiences	Range of length of stay
▪ Client does not know what program does ▪ Client does not know who among case workers is from FOR Families	3 (7%)	17 to 30 days
▪ Client knows about the program, but has not spoken with a home visitor from FOR Families ▪ Program has not been helpful	9 (21%)	13 to 210 days
▪ Client has received primarily an information packet and a resource guide ▪ Client has received advice, counseling, and support	11 (26%)	14 to 300 days
▪ Program was helpful ▪ Client has received specific assistance from the program (i.e., referrals that resulted in a tangible item or service)	20 (46%)	14 to 252 days

Program improvement: Families' perspectives. Families were asked to provide suggestions for program improvements. Twenty families responded that more help is needed to secure housing and transition out of the motels. Fifteen families responded that they need help in general to navigate the system, from knowing how to interact with agencies ' staff when making a phone call to learning how to communicate during a visit to an agency to secure housing or another service. Six families also pointed out that two areas where improvements can be made are the general conditions at the motels and the difficulties with meal preparation and recreational areas for children. Four families indicated that the program is doing a good job as it is. One family indicated that more sensitive case workers are needed and that the program should provide more balanced services, as they felt that the system helps minorities and immigrants more than white families. Table 13 shows the themes derived from responses to the question on program improvements.

Table 12. Families' perspectives on improving the FOR Families Program

Main themes	No. of families*
More help securing housing	20
Help navigating the system	15
General living conditions (e.g., cooking, play areas)	6
Nothing – program doing good job	4
Less attention to immigrant and minorities	1
More sensitive case workers	1

*Notes: *Some families provided a combination of suggestions*

Getting out of homelessness: What is holding families back. When families were asked what they needed to get out of homelessness and what was holding them back, their most frequent responses included lack of jobs, limited affordable housing options, and poor transportation available where they were temporarily sheltered (Table 14). Other frequently reported obstacles included difficulties navigating the system of care for homeless families, including limitations posed by policies and regulations, and lack of childcare for sing le working mothers.

Table 13. Obstacles preventing families from getting out of homelessness

Main obstacles	No. of families
Hard to find jobs Lack of income Difficult economic situation	16
Lack of transportation Location of motel	12
Housing issues: Affordable housing or rent Eviction from home	11
Not knowing the system Not understanding time limits Not understanding what help is available from program(s)	5
Lack of childcare	4
Waiting to get services Waiting to see how the system works Delays	3
Needs to graduate from school	1
No incentive to work	1
CORI (Criminal Offender Record Information)	1
English language skills	1

Getting out of homelessness: What families need to move forward . Table 15 summarizes clients' responses to the question, "What do you need to get out of homelessness?" Most clients indicated that jobs and affordable housing were the two main factors that would enable them to get out of homelessness. Access to better childcare options was mentioned by seven mothers with young children as an enabling factor that would help them move forward.

Table 14. Getting out of homelessness: Clients' views of enabling factors

Main enablers	No. of families*
Affordable Housing	20
Job	19
Daycare	7
Vouchers/financial help	7
Education/training to get job	5
Clothes for job interview	2
Clear rent history	1
Learning English	1

*Notes: *Frequencies include more than one response from one client.*

4.2. Results of Interviews with Home Visitors

The results presented in this section were obtained from telephone interviews conducted with fourteen full time home visitors. The interviews were conducted between May 24 and June 1, 2010.

Caseloads/HV. Home visitors in the West reported the highest caseloads, while home visitors in the NE reported the lowest number of families (Table 16). The Metro/Boston region had the highest number of home visitors at the time of data collection, and the SE region had the lowest number of home visitors during the same period. These figures do not take into a ccount the uneven distribution of families per region.

Table 15. Regional and global caseload: Average number of families per home visitor

Regions	No. of Home Visitors per Region	Average no. of Families per Home Visitor
NE	4	46
SE	2	62
West/Central	3	66
Metro/Boston	6	57
Total	14	54

Half of all home visitors have been in the program for over five years, and one third of all home visitors have been in the program for over eight y ears. Individual caseload ranged from 21 to 78 families at the time of data collection, with an average of 54 families per home visitor. However, the majority (57%) of home visitors had a caseload of 60 to 70+ families during the interview period (Table 17). Home visitors reported frequent changes in the number of families in their caseload.

Table 16. Home visitors' caseload

Home Visitor ID	Caseload: no. of families
HV001	61
HV002	50
HV003	21
HV004	78
HV005	69
HV006	70
HV007	60
HV008	62
HV009	66
HV010	62
HV011	50
HV012	19
HV013	49
HV014	42
Average	*54*

Experiences with the FOR Families Program

Challenges. Home visitors were asked about their experiences working with the program and about the challenges that they face when providing follow -up, outreach, and referral services to the families. Home visitors reported time constraints, large caseloads, limited funding for housing, and structural/programmatic challenges. Other challenges included language barriers when providing services to families, problems with clients' migration status/documentation, program eligibility requirements, policies, location of motels, and limited transportation. The following quotes illustrate some of the main challenges voiced by home visitors.

- *I don't have enough time, and we're always dealing with families in crisis who need more time.*

- *Everything is reactive and not proactive. It is difficult to bring stability and consistency to a family when we don't have it programmatically and administratively.*

- *From a programmatic perspective, we get asked for feedback and little of it is used. The program is becoming more and more rigid. We have no input ; they ask our opinion and they don't translate it to the work. All I hear is don't, don't, don't, wrong, wrong, wrong.*

- *Because I am there weekly, I am going to be honest – if we only had one hotel, the follow-up would be wonderful, but because we have multiple hotels, we can't do the recommended follow-up.*

- *The caseloads are too high. It takes time when you have a new family, with the additional time of an assessment. It is challenging, balanci ng the paperwork and office time with home visits, plus meetings and travel. And then there is always the crisis with families.*

- *Not enough funding for housing program for families. Locations have limited transportation.*

Follow-up, outreach, and referral strategies. Home visitors continue to carry out the traditional Follow-up, Outreach, and Referral activities of the FOR Families Program (e.g., visits to the families, letters, phone calls, advocacy, direct teaching and education, and links to services through referrals). Table 18 summarizes the various follow-up, outreach, and referral strategies that home visitors were implementing at the time of data collection.

Table 17. Follow-up, outreach, and referral strategies

Follow-up	Outreach	Referrals
▪ Schedule appointment with client and see family within a week ▪ Initial visit, complete full assessment ▪ Follow up with a letter and appointment to quickly make a connection with family ▪ Employ good listening skills ▪ Treat each person as an individual ▪ Phone calls ▪ Working from the assessment form as a tool for follow-up ▪ One-on-one teaching ▪ Probing to further define true need ▪ Bring resource packet and FOR Families brochure explaining program to the client	▪ Resource guide ▪ Calling other providers ▪ Get families connected using internal networks ▪ Make referrals from room with client ▪ Follow up two weeks later to see if the referral was followed up ▪ Keep clients up-to-date with physical and dental with all children and adults ▪ Call primary doctors and pediatricians ▪ Connect with WIC if they have younger kids ▪ Find resources and use volunteers and churches ▪ Become familiar with whatever community one is working with and build a relationship. And with the service providers and managers at the hotels, earn their trust and cooperation	▪ Resource guide ▪ Direct phone calls to agencies – the agency will call HV as well as family ▪ Being kept in the loop with what is going on with referrals ▪ Recognize that referrals change quickly ▪ Get to know the referral resources so that HV knows where she/he is sending the families ▪ Communicate with service provider once referral is made to make sure that the help gets through ▪ Make phone call, as the client sees that HV is concerned and that someone cares – this increases likelihood that clients follow up with referrals ▪ Advocate for clients

Working with sister agencies and service coordination. Home visitors were asked about service coordination with other agencies to address the needs of homeless families. They identified a wide range of agencies with which they work on a regular basis to coordinate services for the families, including community-based organizations, non-profit agencies, health care professionals, schools, childcare centers, local universities, and government agencies. The

coordination of such services for the motel/hotel population is conducted by the FOR Families home visitors. Home visitors indicated that there is no formal system of service coordination or care for homeless families at the state level. This activity is being conducted by FOR Families home visitors for a select service population, and, it appears, this has not yet been formalized.

Home visitors reported positive interactions with agencies and organizations providing services to homeless families in the state. They reported th at schools are especially helpful. The majority of home visitors (10 out of 14) indicated that services are coordinated or sometimes co ordinated, although there exist no formal structure for such coordination. For example, there is no mechanism for convening case conferences with multiple providers or any way for home visitors to track the outcomes of referrals. Their comments point to housing, health care, and education/school as areas were coordination appears to work well. Home visitors indicated that there is sometimes overlap with other agencies, and that the difficulties that families face might not be fully recognized or well identified by other agencies. Community -based organizations, in particular, might not understand the overall structure of the s ocial services and the public health systems for families. Some of the difficulties encountered with other agencies include delays in returning telephone calls or delays in providing a specific service. However, home visitors acknowledged that case manager s from other agencies, like themselves, have very high caseloads, making it difficult to provide faster services.

Home visitors reported that services are coordinated through the initial assessment of each family's needs. Current service coordination with other agencies and organizations is conducted primarily by telephone, through email and fax, through informal conversations with other case managers in motel/hotel hallways, and through occasional meetings with community resources. Although it is not true for all areas, agencies do not meet to coordinate services for homeless families. FOR Families home visitors reported being the primary coordinators of services for families living in motels. In this regard, some of their recommendations for improved serv ice coordination includes case management meetings with other agencies, improved communication, a planned approach for service delivery, and a more formalized role for FOR Families home visitors as coordinators of services.

Recommendations. Interviews with home visitors yielded a series of recommendations for program improvements. These have been organized in four categories: recommendations specific to the current housing in motels, those related to programmatic issues, those related to leadership and management, and those related to coordination of services for homeless families . It is important to clarify that these recommendations may be outside the scope, role, and control of the FOR Families Program. However, the recommendations are presented in Table 19 to provide a summary of home visitors' views about areas where program improvements could be made.

Table 18: Sample of home visitors' recommendations for program improvements

Housing in motels
▪ Avoid using motels that are not located near public trans portation as temporary shelter. ▪ Implement an alternative system or services to address families' inability to cook in motels and their lack of access to food.
Programmatic
▪ Increase time with families so that home visitor can get to know them better. ▪ Work closer with families transitioning out of the motels. ▪ Focus less on stabilization and more on prevention. ▪ Work on developing program stability and consistent procedures. ▪ Improve coordination of services with other collateral agencies and other service providers. ▪ Improve database and provide mobile laptops for data entry. ▪ Eliminate paper files. ▪ Address changing nature of program as directed by funding sources and the limitations posed for long term planning by such changes (e.g. program's ability to implemen t a 5-year plan). ▪ Improve internal program coordination with other regions and regional coordinators. ▪ Change program description to more accurately reflect what HV are doing as a broker for clients. ▪ Implement mechanisms that enable home visitor to have an actual, direct connection to the basic needs (e.g., call food pantry directly)
Leadership & program management
▪ Provide tasks changes in writing ▪ Be understanding and reasonable about how quickly home visitors can see new families when caseloads fluctuate. ▪ Learn to listen to staff and value their input. ▪ Increase flexibility from program management. ▪ Stop emphasizing what we are doing wrong and start looking at what we are doing right. ▪ Learn how to value what people do. ▪ Implement a more democratic process to g ather input from workers.
Coordination of services for homeless families
▪ Implement a more accessible and faster housing search procedure. ▪ Implement case management meetings with other agencies. ▪ Increase number of home visitors and case managers; and redu ce caseload. ▪ Increase funding.

Program components that are working well. Home visitors identified several program components that are working well. These include staff commitment to families; relationships with other agencies; the FOR Families Program's reputation; coordination of follow up and referrals with other agencies; effective networks; diverse and united staff; good supervisors; and a strong program mission, purpose, and structure. Table 20 summarizes home visitors' comments regarding program com ponents that are working well.

Table 19. Program Strengths: Components of the FOR Families Program that are working well

Program Strengths
▪ Commitment of program staff to the families
▪ Effective support networks
▪ Good responsiveness from the health provider community
▪ Good, diverse, and committed staff and regional coordinators
▪ Unity and good communication among workers
▪ Good program structure and great mission
▪ Pilot funding programs to get families out of motels recently implemented
▪ Quick response from FOR Families home visitors to DHCD requests; dependability
▪ Strength of an established, good relationship with key agencies such as the DHCD and the DCF
▪ Good coordination of services with early intervention, domestic violence, or substance abuse programs
▪ Role of FOR Families home visitors as liaisons with school system

Accomplishments. Home visitors were asked to list some of their accomplishments working with families sheltered in motels throughout the state. Their accomplishments can be grouped under four main themes: crisis containment/management, empowerment of families, connecting families to services, and management of large caseloads. Examples identified by home visitors as accomplishments linked to their outreach and referral efforts include providing referrals that resulted in housing for the families; helping families' access health services, food, and educational/training services; providing referrals that helped families move out of the motel system; helping family members secure employment; and being able to see families at least once despite large caseloads. Home visitors' responses to this question suggest that they have achieved meaningful outcomes with their case management work with families sheltered in motels throughout the state despite limited time with the families and large caseloads. Table 21 summarizes home visitors' responses to the question about their accomplishments.

Table 20. Summary of accomplishments

Main theme	Representative quotation
Crisis containment/management	▪ *Preventing crisis from escalating; there are no long term goals with the clients so we have to put out fires and prevent problems from occurring. Being able to work with what we have and working with crisis of the day.*
Empowerment of families	▪ *We can empower people through the process to do things on their own that they didn't think they could.* ▪ *A major accomplishment for me has been helping people hold on to hope. They feel like total failures and I help them hold on to something that gives them strength to make it.* ▪ *I will provide a voice for the families with the medical system to get the families what they need. In doing so, I get to show them that it's okay to advocate for yourself and be a little bit pushy when necessary. That's an accomplishment for me*.
Connecting families with services	▪ *I've had a couple of families secure employment who had nothing before.* ▪ *Referring families to appropriate services; school placement, clothing and transportation, families getting jobs.* ▪ *Not seeing families come back into shelters.* ▪ *Three of my families are moving out. I connected them with a housing search provider.* ▪ *Mental health – family connected with home visiting counselor and they are in the process of getting involved in mental health program and after school programs for child and they are able to get referrals for other services.* ▪ *Getting families back in school with ESL and GED accomplishments.* ▪ *Connected with proper medical care, childcare services, appropriate food resources, employment referrals.*
Management of large caseloads	▪ *Seeing over 80 families and being able to see them at least once a month with 10 new families a week.*

4.3. Interviews with Program Management

The data presented in this section were obtained after completion of data collection, analysis, and interpretation of the evaluation as per the original evaluation plan. These interviews with members of the program management were completed in April 2011. Two individuals answered

the interview questions that were originally designed for FOR Families home visitors. Response to the interview questions were typed and submitted via email.

In general, the responses from program management staff mirror the responses provided by home visitors regarding their experiences with the program. Their responses fo cused on program challenges, provision of services, and recommendations.

Experiences with the FOR Families Program

Challenges. Both respondents identified challenges similar to the challenges that home visitors reported. These include large case loads, fa milies moving out of motels prior to assessment, limited staff, transportation, and limited funding/resources. As one respondent stated:

> *"It is challenging for staff to meet the monthly follow up goal at times due to high caseloads, having multiple new p lacements at once and some clients are not responsive to HVs outreach attempts and don't make themselves available to meet with staff. In addition to those reasons, they have to manage any crisis/concerns that come up unexpectedly."*

The same respondent provided more specific insights into the challenges that t he FOR Families program faces, identifying several challenges including (1) deeper issues inside the families (child abuse/neglect, health concerns for families), (2) families' placement away from support system, (3) safety concerns (gang violence, intimate partner violence, and family violence), (4) challenges faced by staff (staff burnout, secondary trauma, job satisfaction), (5) programmatic difficulties (changes in program and staff's role over time) and (6) program's ability to address families' needs in the context of more complex family circumstances (clients with multiple housing barriers such as negative CORI, poor credit rating, multiple evictions, and lack of job skills; clients with sub stance abuse and/or mental health issues, encouraging treatment but also figuring out the best way to work with those who do not want treatment).

Follow-up, outreach, and referral strategies. Both respondents identified follow up, outreach, and referral strategies similar to the ones identified by home visitors. These strategies include telephone calls, letters, phone reminders, phone calls to check in, phone calls to agencies for referrals, repeated attempts to contact clients, c hecking in with the motel staff about difficult-to-reach clients, knowledge of local resources for referrals, establishment of relationships with providers in the geographic area of service, finding services for families that can be provided at the motel, and a consistent presence at specific motels.

Working with sister agencies and service coordination. Respondents identified various programs and agencies working directly with homeless families and coordinating services with the FOR Families program: community-based organizati ons, non-profit agencies, health care and mental health services, government agencies, and specific programs such as Early Intervention and WIC. One respondent pointed out that there is variation statewide on the type of agencies, organizations, or progra ms within each region working with homeless families. Both respondents indicated that service coordination occurs sometimes. One respondent indicated that *"[c]ollaboration takes effort. Building relationships and maintaining regular communication with those agencies we refer to often help the collaborative process."* Respondents indicated

that services are coordinated through phone calls to the agencies, emails, meetings, and collaborative visits. They provided suggestions for the improvement of service coordination such as maintaining regularly scheduled communication with the providers with whom FOR Families works frequently, and decreasing home visitors' caseloads to increase time available to work with families, including the coordination of services with other agencies.

Recommendations. Respondents' suggestions presented in this section are similar to the recommendations reported by home visitors (Table 19). These recommendations are related to staffing needs, program management, and coordination of services for homeless families. The following list summarizes the recommendations presented by the two respondents.

- Staffing
  - Program needs to be fully staffed;
  - Faster hiring process in the DPH ;
  - Increasing the number of bilingual staff; and
  - Increasing number of home visitors to address high caseload.
- Programmatic
  - Development and implementation of an integrated database with DHCD;
  - Improved communication between DPH senior staff and DHCD senior staff on how the FOR Families program fits in DHCD's longer term plans. Clarifying the role of FOR Families within the longer plans of the DHCD would allow better internal planning; and
  - Provision of laptops to assist with work in the field.

Program components that are working well. Respondents highlighted the following areas as program components that are working well:

- Dedicated staff;
- Direct work of home visitors providing direction, support, referrals, and assistance to the families;
- Excellent working relationships with sister agencies such as the DHCD;
- Program's reputation and respect;
- Staff's quick response to issues/crisis; and
- Strong linkages and relationships with local communities and motel staff.

4.4. FOR Families Database

The data presented below were obtained from the FOR Families database for the period of October 2008 to March 2010. Missing data were removed from the analysis. When applicable, missing frequencies are noted below the tables included in this section. Some of the reasons that may explain missing data are: data entry not completed, data were entered incorrectly, or participants refused to answer certain questions or provide information at the time of intake.

These descriptive data are representative only of the homeless clients with at least one point of contact with a FOR Families staff member providing service. These data may not reflect the characteristics of the overall homeless family population in Massachusetts. In FY10, economic and social factors contributed to a rise in the number of families experiencing a crisis and losing, or at risk for losing stable housing. FOR Families responds to either (Department of Transitional

Assistance) DTA's or DHCD's need for services. During an economic downturn, the program is asked to serve those families most impacted by the economic cris is. In 2009, this crisis contributed to large numbers of families losing their housing and being temporarily sheltered in hotels and motels (2,523 clients in FY10 alone). The types of contacts and referrals provided by the program's home visitors reflect the crises that families experience. A difference in the value of specific data elements this year compared to previous years may simply reflect a change in the population participating in/referred into the program.

Analyzable program data is that which is collected by home visitors on a simple computerized form that is used upon intake of a client. Since this database mostly collects characteristics of the population served, only limited inferences can be made about the impact of the program and the progress made by its clients over the course of their service. Furthermore, since families may move out of temporary housing quickly, it can be difficult to track their progress over time. Additionally, a high rate of missing data (for example, close to half of clients has a missing value for age/date of birth) contributes to the apparently fluctuating population size across different variables among FOR Families' 3,169 FY09 clients. Participants with missing values for data elements are not included in the analysis of those data elements. Excluded participants (i.e. those with missing values) may be different from the individuals with complete information. Consequently, the population that is included in some analyses may not be representative of the total population that has participated in the program.

Family composition. Families enrolled in the FOR Families Program during the period of October 2008 to March 2010 were composed primarily of a parent, typically a single mother, with a child. The mean family size was 2.8, with families ranging from 1 member (a pregnant woman) to 10 members (Table 22). Most families (92.5%) were headed by a female and the majority of family units had between 2 (41%) and 3 (29%) children.

Table 21. Gender of head of household

Gender	***f***	**%**
Female	3704	92.5
Male	302	7.5

Notes: Frequency missing: 377

The median age of heads of family units was 27 -years-old, with an age range of 17 to 67 years (Table 23). The majority of children were under the age of 10 (Figure 6). Over two-thirds (65.6%) of heads of households in the sample had a high school education, with 20% having some college but without completion of a college degree (Table 24).

Table 22. Age of head of household by sex and region

Characteristic	No. obs	N	Mean	Std Dev	Mdn	Min	Max
Age/Region							
Boston	844	761	30.1	9.2	27	17	67
Central	401	192	29.5	7.2	28	19	54
Metro	246	184	28.8	8.5	26	18	57
NE	1069	636	29.5	8.6	27	17	65
SE	845	702	29.6	8.8	28	18	110
West	786	655	28.4	7.7	26	17	59
Age/Sex							
Female	--	2927	28.8	--	27	17	110
Male	--	225	36.9	--	37	16	67

Table 23. Educational levels of heads of households

Educational levels	*f* (%)
Some schooling/No HS	338 (11.1)
Some HS	974 (32)
HS diploma	1024 (33.6)
Some college	612 (20.1)
College degree or higher	96 (3.2)

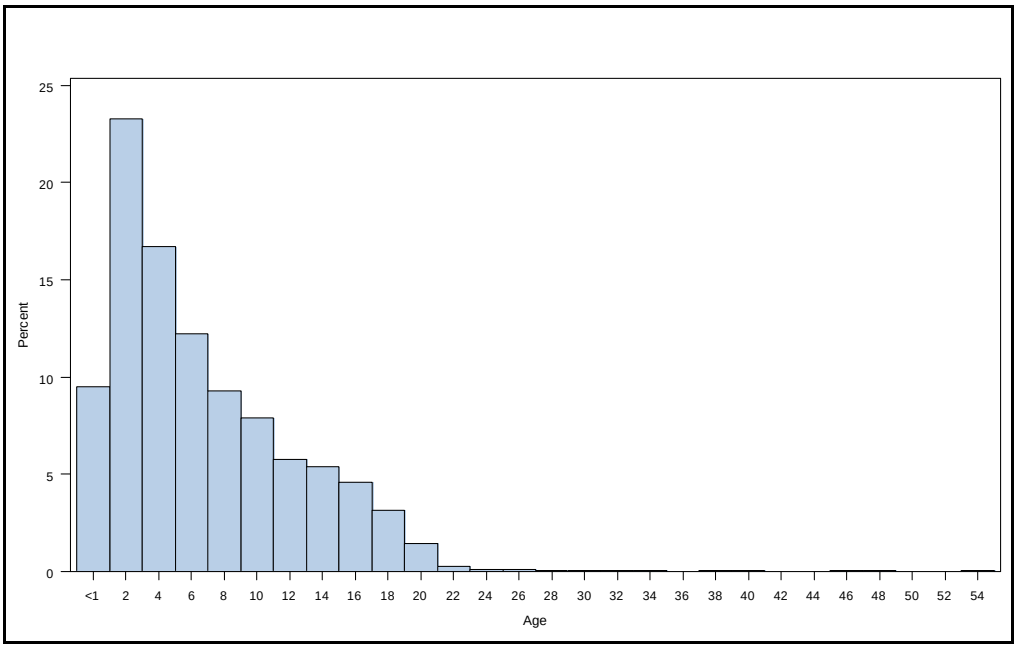
Notes: Frequency Missing = 1339

Table 24. Distribution of population by family size and number of children

Family size	*f* (%)	No. of children	*f* (%)
1	200 (5.7)	0	146 (4.3)
2	1430 (41.1)	1	1665 (48.7)
3	1032 (29.6)	2	972 (28.5)
4	558 (16)	3	448 (13.1)
5	180 (5.2)	4	132 (3.9)
6	48 (1.4)	5	33 (1)
7	26 (0.8)	6	16 (0.5)
8	5 (0.4)	7	4 (0.12)
9	2 (0.1)	9	1 (0.03)
10	1 (0.03)	----	----

Notes: Frequency Missing Number of children = 9 66

Figure 6. Distribution of ages of children in sample (n=4383)



Length of stay, contacts, referrals. Between October 2008 and March 2010, nearly 45% of clients who were enrolled in the FOR Families Program spent one month or less in the motels and received follow-up, outreach, and referral services from the program. Five percent of clients had a length of stay of 7 months or more. The average length of stay in months for families enrolled in the program during this period was 2.3 6 months. On the average, most clients received 9.87 contacts from their home visitors, with a range of contacts between 0 and 180 , and 3.9 referrals, with a range of referrals between 0 and 47. About 23% of the population was contacted between 11 and 20 times, and a small number of families (1.4%) received over 40 contacts during this period.. However, data on the number of referrals per client show that close to 40% of the families received no contacts from a home visitor during the period considered. Table 26 summarizes the length of stay, the number of contacts, and the number of referrals per client that occurred between October 2008 and March 2010 , and figures 7, 8, and 9 show the distribution of length of stay in months, contacts, and referrals among clients. When the length of stay was compared with the size of family, significant relationships were found between the number of families who have 2, 3, 4 or 7+ members and how long they stayed in the program (Tables 27 & 28).

Table 25. Length of stay in months, number of contacts, and number of referrals per client

Length of Stay	*f* (%)	No. of contacts per client	*f* (%)	No. of referrals per client	*f* (%)
	M = 2.36		***M*** = 9.87		***M*** = 3.94
0	1034 (23.6)	0	72 (1.6)	0	1643 (37.5)
1	1006 (23)	1	191 (4.4)	1	255 (5.8)
2	660 (15.1)	2	389 (8.9)	2	283 (6.5)
3	523 (12)	3	416 (9.5)	3	312 (7.1)
4	416 (9.5)	4	331 (7.6)	4	274 (6.3)
5	297 (6.8)	5	288 (6.6)	5	267 (6.1)
6	196 (4.5)	6	306 (7)	6	223 (5.1)
7-12	237 (5.4)	7	292 (6.7)	7	181 (4.1)
Over 12	14 (0.32)	8	231 (5.3)	8	180 (4.1)
		9	232 (5.3)	9	184 (4.2)
		10	178 (4.1)	10	152 (3.5)
		11–20	1005 (22.9)	11–20	407 (9.3)
		21–30	289 (6.6)	Over 20	22 (0.5)
		31–40	101(2.3)		
		Over 40	62 (1.4)		

Figure 7. Distribution of length of stay in months in the sample (n=4383)

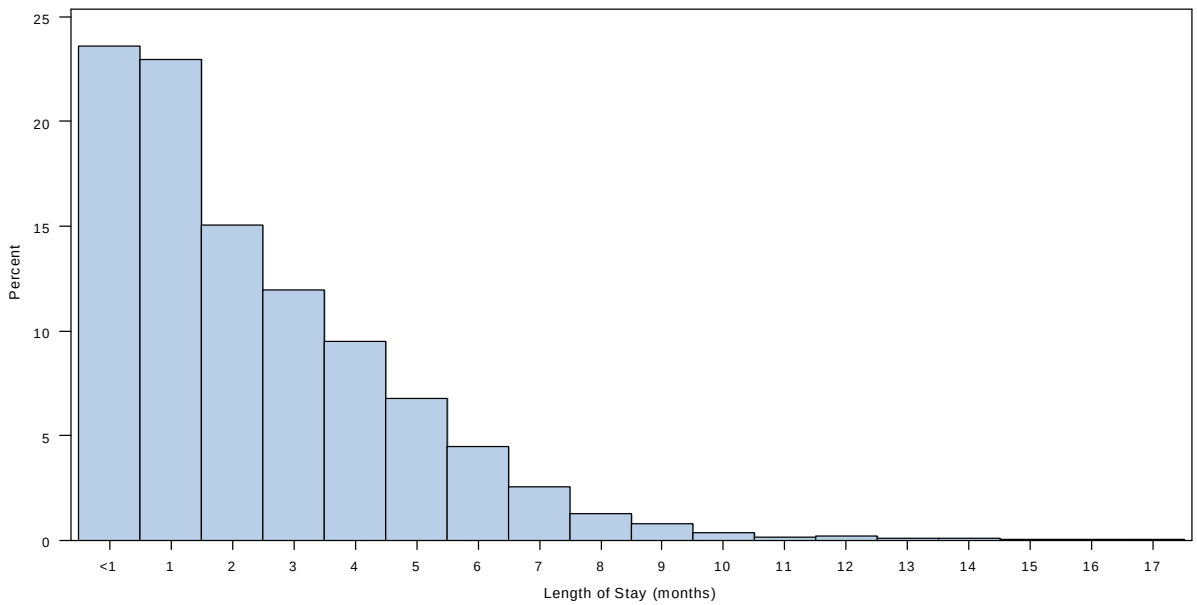


Figure 8. Distribution of number of contacts in the sample (n=4383)

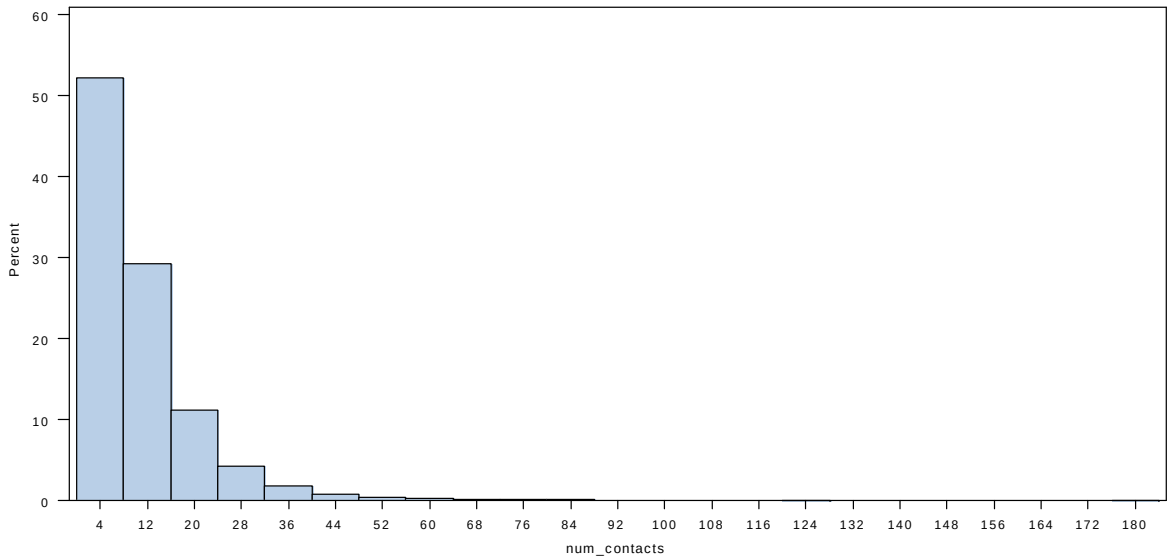


Figure 9. Distribution of referrals in the sample (n=4383)

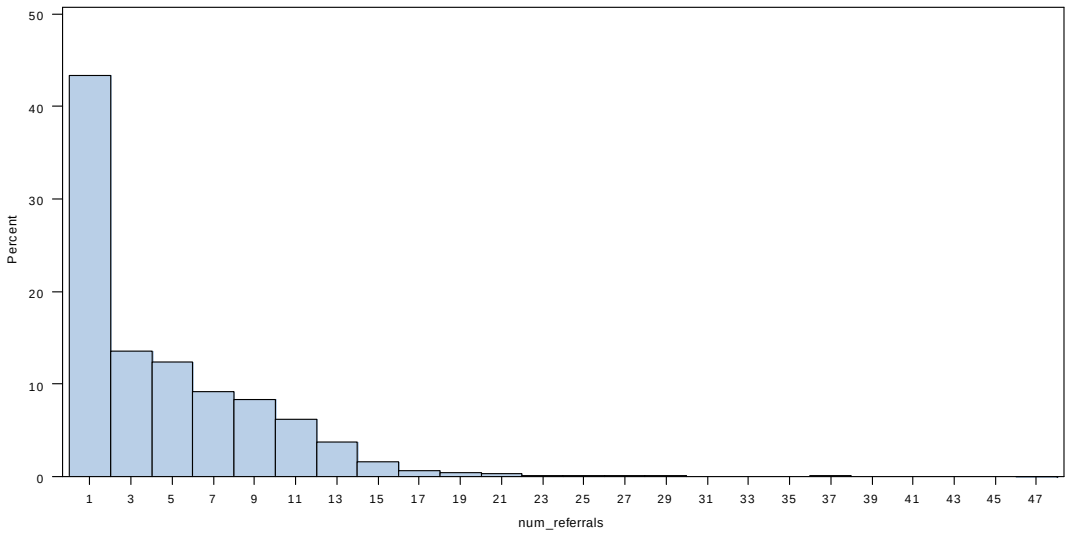


Table 26: Length of Stay in Months by family size

Family size	No. of obs	Mean	Std Dev	Lower 95% CL for Mean	Upper 95% CL for Mean	Min	Max
1	200	1.86	1.82	1.61	2.11	0	10
2	1430	3.14	2.52	3.01	3.27	0	16
3	1032	2.93	2.33	2.78	3.07	0	15
4	558	2.28	2.05	2.11	2.46	0	17
5	180	1.66	1.85	1.38	1.93	0	11
6	48	1.31	1.49	0.88	1.75	0	8
7 to 10	34	2.18	2.39	1.34	3.01	0	11

Table 27. Length of stay, contacts, and referrals by region

Region	Length of Stay (months)			Contacts per Client			Referrals per Client		
	Mean	Mdn	CI	Mean	Mdn	CI	Mean	Mdn	CI
Boston	3.4	3	3.28–3.61	15.80	13	15–16.6	6.6	6	6.30–6.96
Central	0.8	1	0.75–0.97	5.86	4	4.78–6.94	4.7	0	4.12–5.28
Metro West	2.2	1	1.94–2.54	8.64	7	7.75–9.53	4.0	4	3.53–4.47
NE	2.4	2	2.27–2.55	7.83	6	7.43–8.22	2.5	1	2.33–2.76
SE	1.5	1	1.43–1.66	11.00	8	10.3–11.7	3.5	3	3.30–3.77
West	3.0	2	2.90–3.25	9.05	7	8.51–9.6	3.8	1	3.52–4.21

4.5. Initial Document Review

Seventy-eight randomly selected family assessment forms were reviewed. These assessments were completed by home visitors at the time of the families' entry in the program, and represent all regions where families currently receive services. The mean age of heads of household for this sample is 28.5, with the youngest head of a family unit being 16 years old and the oldest 55 years old. Reasons for homelessness in this subsample mirror the two other data sources, with family reasons that ranged from doubling up to inability to continue living with relatives and conflicts with family members as the most frequently reported reason at the time of intake, followed by domestic violence and lack of affordable housing/rent. In addition, the majority of clients reported various situations that affect household members including health problems, mental health problems, and CORI issues (Figure 10). Asthma and pregnancy were the health needs most frequently reported in the assessment forms (Table 29).

Figure 10. Situations affecting family units at the time of assessment (n=78)

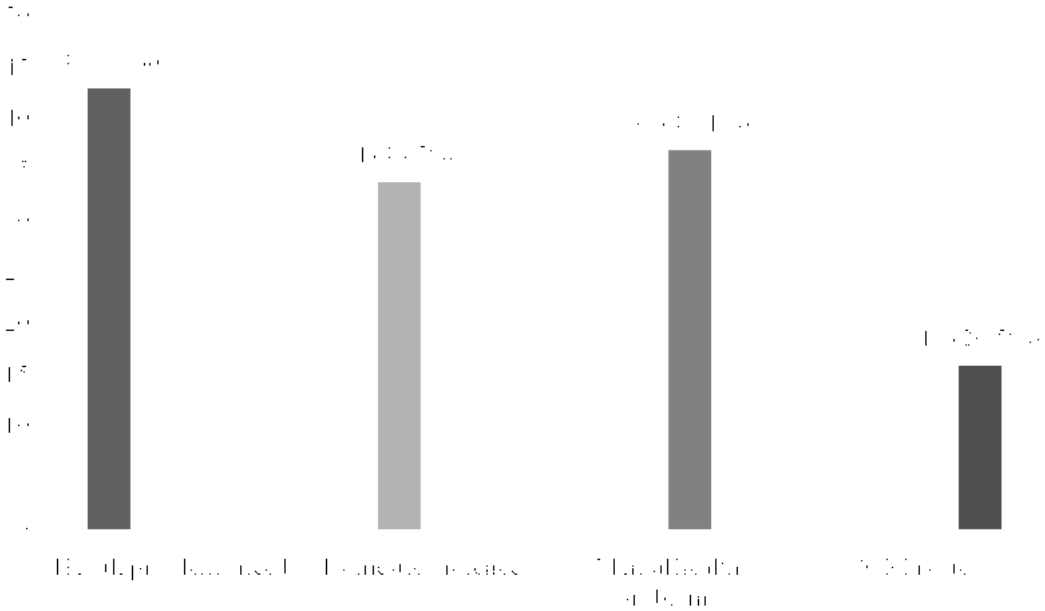


Table 28. Type of health needs/problems reported by heads of family units at the time of assessment

Health Needs/Problem	# of times Reported
Mental health (all)	37
Types: ▪ Depression ▪ History of sexual abuse ▪ Trauma ▪ Post-partum depression ▪ PTSD ▪ Bipolar disorder ▪ Suicidal tendencies ▪ Anxiety ▪ ADHD	
Diabetes	4
Birth Control	3
Headaches/Migraines	3
Back/Neck pain	2
Epilepsy	2
Anemia	2
Other	41
Total	**94**

5. CONCLUSION

The purpose of this report was (a) to present the final findings of the 2010 FOR Families formative and program evaluation to key program stakeholders, and (b) to obtain initial feedback regarding the results prior to wider dissemination. This evaluation found that families served by the program became homeless for three primary reasons: lack of affordable housing, lack of jobs, and inability to continue living with relatives and friends. The dominant profile of homeless families in the program is that of a single mother in her late 20s with 2 children under the age of 5. It appears that very small and large families participating in the program transitioned out of the motels much sooner than families with 2 to 4 members. The reasons for this finding are unclear. Regardless of family size or region, home visitors provided similar case management to all families, tailoring case management strategies to the specific needs of the families. Large caseloads and limited time with families are two significant barriers that home visitors currently face in the delivery of follow-up, outreach, and referral services. Home visitors work closely with multiple sister agencies, programs, and community-based groups to provide services to homeless families.

6. RECOMMENDATIONS

6.1. Services to families

1. The findings indicate that jobs and training are two areas of high need, particularly among heads of households who are primarily single mothers. In collaboration with other agencies and organizations, including the private/business sector, strengthen current referral systems in this domain with a focus on single mothers. The following are some ideas:
    a. Develop a strong collaboration with career mentoring programs to pair mothers with volunteer career/job mentors who can help them navigate job interviews and conduct job searches. Home visitors should work directly with volunteer career/job mentors.
    b. Partner with community agencies to explore mechanisms (in addition to the voucher system) to provide transportation to parents seeking employment in locations where the bus system is not reliable or the cost of taxis is too high.
    c. Partner with community agencies to explore possibilities of a mobile job fair or mobile counseling unit that can rotate from community to community in locations near the motels to provide job/career counseling services for families residing in motels.
2. Consider the possibility of screening all families entering the program for mental health needs. Implement a screening protocol for this purpose, and increase staff capacity to address needs in this domain through training and coordination of additional support services for families. Revisit screening ideas gathered during the 2006 FOR Families qualitative program evaluation that included screening and prevention *(note that the recent Emergency Assistance Reform in Massachusetts report released on December 2010 brings prevention to the forefront as a focus area of high interest. Prevention is also a focus area recommended by*

the Special Commission Relative to Ending Homelessness in the Commonwealth convened by Governor Deval Patrick in 2007).[1,2]

3. Given the number of mothers reporting situations of domestic abuse, consider increasing and strengthening the number of referrals for support and counseling services with local agencies that can bring services to families housed in the motels (e.g., weekly support groups or group counseling). If policy constraints, structural barriers, and concerns about creating a dependency culture pose limitations, consider alternative services such as telephone counseling. Research shows that survivors of abuse continue to experience trauma after being removed from the situation of abuse, and that these experiences pose additional challenges to the mother's ability to transition out of homelessness, parent her children, and secure employment.[3]

6.2. Programmatic: Staff and Program Coordination

4. Consider a model of care for homeless families that is redefined as an emergency response versus home visiting program. Look at core elements of emergency management and decision-making protocols versus home visiting core elements.
5. Revisit the home visitors' job description regarding coordination of services to homeless families in light of their perceptions and understanding about this role. Engage in a follow-up conversation with home visitors to understand their views regarding the current status of service coordination for homeless families (in motels) in the state and their role as coordinators of services for homeless families.
6. If the state (DPH/DHCD) decides to keep FOR Families as a home visiting program, reinstate the previous model of intensive case management, which allowed home visitors to spend more time with families; systematically assess their needs, barriers, assets, and strengths; and tailor strategies to the needs of family members. Consider a coordination of needs assessment with other agencies currently working with the families in motels, particularly agencies that provide services to mothers and children (note that among families interviewed at the time of this evaluation, 55% of all family members were children 17-years-old or younger; 34% of all family members were 5-years-old or younger).[4]
7. Develop mechanisms that allow home visitors to voice their programmatic, leadership, and management concerns in a safe forum. Listen to the concerns of home visitors directly and engage in a frank exchange of ideas and solutions. Consider contracting with an outside agency to facilitate such a forum.
8. Capitalize on the program's strengths to respond to crisis situations and to manage emergencies, while retaining the program's strengths as a home visiting program. Examine a hybrid model option.

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[1] Curnan, S. P. (2010). *Emergency Assistance (EA) Reform in Massachusetts: A Report from Ten Regional Forums. Center for Youth and Communities.* The Heller School of Social Policy and Management, Brandeis University. Boston, MA.
[2] Note: would be feasible because this can be seen as a primary role for FF.

[3] Note: would be feasible because this can be seen as a primary role for FF.
[4] Note that this cannot happen unless the program goes back to the home visiting model. The core elements of each model would need to be further explored under this scenario. In addition, a deeper conversation about what FOR Families wants to do would need to occur.

9. Strengthen the capacity of home visitors and regional coordinators by increasing the number of home visitors and decreasing the number of families per home visitor. Consider hiring and training support staff who can help with families who have fewer and less complex needs. Continue capacity building through ongoing training and retention of skilled, multilingual staff. Consider providing training and certification mechanisms to program staff in key areas, such as mental health, domestic violence, substance abuse, and child safety. Align staffing needs as much as possible with program needs.

6.3. Interagency Communication

10. Given current conversations at the state level regarding services for homeless families, and in light of the recent reports regarding emergency assistance and family homelessness, [5,6] engage in conversations with key state agencies about the current status of the coordination of services for homeless families; capitalize on the years of combined work and experience that FOR Families staff have with regards to addressing the needs of homel ess families in the state. FOR Families' staff at all levels are uniquely positioned to provide recommendations for working with homeless families that no other agency in the state could offer.
11. Engage in conversation with key agencies at the state level (e .g., housing, education) to develop a more formalized system of service coordination for homeless families. Invite all home visitors to participate directly in such conversations as they offer unique perspectives and experience working with homeless famili es. Encourage communication at all levels.
12. Continue to support the participation of FOR Families in the Interagency Council on Housing and Homelessness, a group experimenting with strategies to move families out of homelessness.[7]

6.4. Data, Monitoring, and Program Evaluation[8]

13. Conduct an analytic study to further assess the significance of the relationship between length of stay and family size. Employ internal epidemiological capacity to design and conduct this study. The descriptive statistics collected su ggest that length of stay (measured in months) in the program is lower when families are composed of one family member (pregnant woman) or when families have 5 to 6 members and higher when the family size is 2, 3, 4 or 7+ members. Closely assess the charac teristics of families who stay longer in the program and who receive a larger number of contacts/referrals to determine a service use pattern. There are programmatic and policy implications linked to this finding that may result in modifications that could move families out of the shelter system faster, reduce the length of stay of families in the motels, and reduce program costs.

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[5] Curnan, S. P. (2010). *Emergency Assistance (EA) Reform in Massachusetts: A Report from Ten Regional Forums. Center for Youth and Communities.* The Heller School of Social Policy and Management, Brandeis University. Boston, MA.
[6] Culhane, D. P. & Burne, T. (2010). *Ending Family Homelessness in Massachusetts: A New Approach to the Emergency Assistance (EA) Program*. White paper commissioned by the Paul and Phyllis Fireman Charitable Foundation.
[7] Note: 12 may need to be adjusted, depending on the final decision concerning whether FF is an emergency response program or a HV program.
[8] Note: 13-16 may need to be adjusted, depending on the final decision concerning whether FF is an emergency respons e program or a HV program.

14. Using the FOR Families database, and in light of the number of mental health problems reported by families, conduct a descriptive epidemiologic study to evaluate trends in mental health problems among homeless families who have been served by the FOR Families program. Consider a similar descriptive study for other problems reported, such as domestic violence and substance abuse. Use internal epidemiologic capacity and expertise to design and conduct such studies.
15. Develop specific program measures related to mental health, child health, and maternal health to monitor and possibly contribute to evaluating program outcomes, both in the short term and the long term.
16. Acquire dedicated support for internal program monitoring and evaluation. Conduct short term, internal process evaluations to assess how the program is working, particularly in times when families enter and exit the program quickly.

7. APPENDICES

Appendix A. FOR Families Short Interview

ID#: _____ Interviewer's initials: _____

Region: _____ Date of interview: _____/____/2010

Motel/Hotel: _____

Q #1. Family composition

No.	Relationship to head of family unit (person answering survey)	Sex M/F	Age	Race/Ethnicity
1	**Head of family unit**			
2				
3				
4				
5				

Q #2. Education of family members

No.	Family members	Education
1	**Head of family unit**	
2		
3		
4		
5		

Q #3. Current health status of family members as reported by head of family unit [probe in the following areas: mental health, substance abuse, violence, disabilities]

Family members	Types of health problems in the last 30 days
Head of family unit	

Q #4. When was your family placed in this motel/hotel? Date or length of stay:

_____

Q #5. When did you become homeless?

_____

Q #6. Why did you become homeless?

_____ _____

Q #7. What services have you received since your placement in the motel in the following areas?

Domains of need	Type of services received from program	Did you follow up? Y/N	Outcome
Housing			
Food security/nutrition			
Family economics			
Clothing, hygiene products, etc.			
Physical health			
Emotional health			
Social/community/ family support			

Q #8. What are your current sources of support?

Financial	Family	Social

Q #9. What were your sources of support before becoming home less? If you needed help, to whom would you go, where would you go, who would help you?

Financial	Family	Social

Q #10. How has FOR Families been helpful to you and your family? Tell me a few (1 –2) things about the program that have been helpful.

Q #11. How about things that can be improved? What would you change? What has not been as helpful to you and your family?

Q #12. Can you tell me some of the things that are holding you back (preventing you from getting out of homelessness)? [Interviewer: explore barriers to self-sufficiency] (e.g., monthly income, rent payment, domestic violence, substance abuse, mental health problems, lack of job, health of family members)

Q #13: What do you need to get out of this situation? (e.g., job, affordable housing/rent, education, support from family, something like stable transportation, money, health insurance)

Q #14. Where do you see yourself and your family in the next 6 to 12 months?

Appendix B. Home Visitors Telephone Interviews

ID#: _____ Interviewer's Initials: _____
Date: _____ / _____/ _____

1. Region
   ☐ NE ☐ SE ☐ West ☐ Boston
2. What is your current caseload? (number of families) by motel/hotel

Motel/hotel	Location (city)	No. of families

3. For how long have you worked with the program? ____ years, ____ months
4. What do you like about being a home visitor?
5. What is the recommended minimum of visits to the families (or schedule of visits)?
6. How often are you able to visit your families (weekly, monthly, other)?
7. What kinds of barriers or challenges do you face in visiting your families more regularly or as recommended?
8. From your perspective as a home visitor, what strategies have worked for you in reaching families in motels/hotels and providing services in the following specific program activities?

Follow-up	Outreach	Referrals

9. Are there other agencies, organizations, or programs in your region working with homeless families in motels/hotels?

Name of agency, organization, or program	Type of services that they provide

10. How has it been working with other agencies (government, community -based) to assist homeless families? Has it been helpful to you as far as the work that you do with the families (e.g., identifying services, referrals, connecting families with other agencies)?

11. Are services for homeless families coordinated with other agencies?
    - ☐ Yes
    - ☐ No
    - ☐ Sometimes
12. How are services coordinated with other agencies?
13. How can service coordination be improved?
14. What kind of challenges is the program facin g in working with homeless families?
15. What aspects of the program would you like to see changed or improved?
16. What aspects of the program would you say are working well?
17. If you were to list at least two of your accomplishments working with families in the mo tels, what would those be?
    - In the last month
    - In the last three months
    - In the last year